Pay for Success
Opportunities for Public Health Investment
The Pay for Success roadmap for public health

May 2016

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A handbook to assist in getting started with Pay for Success in public health
The Green & Healthy Homes Initiative (GHHI), founded in 1986, is a national 501(c)3 nonprofit organization that provides evidence-based direct services and technical assistance to create healthy, safe and energy efficient homes to improve health, economic and social outcomes for low-income families while reducing public and private healthcare costs.

We would like to acknowledge the work of all of our partners as well as the broader Social Innovation team at GHHI Brendan Brown, Kevin Chan, and Trent Van Alfen for their work contributing to the production of this work.
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This document will serve as a getting-started handbook for Pay for Success projects, especially in public health.

Purpose of this document
The purpose of this report is inform a broad audience by answering the following questions:

- What is Pay for Success?
- As a basic premise, how does it work?
- What is the process, who is involved, and at what points?
- Where has this been used before?
- How does it affect budgets?
- How effective can Pay for Success be at lowering the long-run cost of care in public health?
- What is the ultimate end-game for Pay for Success projects?
- What are the prospects for Pay for Success in public health and what are the key issues facing projects?
- How do differing payment arrangement types affect Pay for Success project viability?
- How do different transaction structures that include different parties affect the viability of Pay for Success projects?
- What should I do next if I want to explore Pay for Success?

Pay for Success in a sentence
If someone is willing to pay for the results but not make the initial investment, then a financing arrangement can be reached where an investor funds a project instead.

When it matters
Pay for Success excels in situations where:
- The money might not be available,
- The project beneficiary is not willing to take the risk, or
- It is uncertain if the program works and proof is needed.

What Pay for Success does well
Pay for Success is a financing agreement that:
- Raises capital,
- Has an investor take a risk instead of the payer, and
- Acts as a proof of concept demonstrating that the business system can work and building a body of evidence for the effectiveness or lack thereof for the program.

Why this all matters
Pay for Success represents a major opportunity, especially in public health, where it can:

Help governments to:
- Align the incentives of governments, private investors, components of health systems, and their patients;
- Infuse private investment capital into preventative care services;
- Improve the rate of medical system improvement;
- Improve health outcomes across the country; and
- Develop a mechanism for evidence-based policy progress.

Help private entities:
- Find investment dollars for rapid innovation;
- Improve the quality of evidence-based care; and
- Develop sustainable funding sources for programs.

For more information, contact GHHI: pfs@ghhi.org

Source(s): GHHI analysis of publicly available information.
Pay for Success 101: The framework

In Pay for Success, an investor funds a project where you only pay for proven outcomes at the price you negotiate.

1. The investor(s) provide(s) upfront capital for service delivery
2. The intervention provider(s) implement(s) intervention(s) for the target population
3. The intervention program results in a benefit to the Payer(s), usually measured in cost saving
4. The payer(s) return(s) capital to the investor(s) if outcomes are met, often verified by an independent evaluator
5. An intermediary may provide project- and financial-management services
6. A project evaluation can create valuable input for future public policy and social learning

Pay for Success solves the problems of
- Capital availability and
- Capital accountability.

Capital availability
Private investors can fill gaps in public investment budgets, so long as they can earn a return if and when the program works.

Capital accountability
Private investors earn returns by taking risk. Their due-diligence before a project starts and the independent evaluation of program outcomes ensures that the payer’s capital is spent on what works and at a pre-negotiated rate.

Source(s): GHHI analysis of publicly available information.
Pay for Success transactions typically start with a feasibility study, moving to structuring the transaction, finally launching an active project.

**Project phases**

- **Feasibility study and Capacity building**
- **Transaction structuring**
- **Active project**

**Project milestones**

- Feasibility determination
- Launch

**Pay for Success project development**

Developing a Pay for Success transaction is a widely differing process. It can be as highly involved as standing up a new program to implement research findings or as simple as developing a sustainable funding source for an existing program. Early projects have been initiated as quickly as months after conception while some have been in the works for years.

There are also multiple parties that guide a transaction to launch. The two primary roles are those of a technical assistance provider and an intermediary. Typically a technical assistance provider will cover capacity building and the initial feasibility study, while an intermediary will structure the transaction and manage it after launch. One party may play both roles but either or both roles may be played by multiple different parties.

**Phases of Pay for Success project development**

There are typically three phases in Pay for Success transactions, though the content varies widely.

- **Feasibility study and capacity building** are typical first steps to enter into a Pay for Success transaction. They aim to identify if it is possible to create a transaction, what the possible gaps are, and how they can be filled. This may involve a pilot program, extensive analysis, and substantial efforts to build programmatic or institutional ability to deliver services.

- **Transaction structuring** for projects deemed feasible will typically begin involving investors and work to develop the terms under which they are willing to invest.

- **Active projects** are the result of transaction launches. This is the period in which actual services are delivered.

Source(s): GHHI analysis of publicly available information.
The field has grown to 11 launched transactions in the United States, with many more in development.

### National PFS launches
- CT Family Stability Project
- SC Nurse Family Partnership
- Denver Social Impact Bond Program
- Santa Clara Project Welcome Home
- Cuyahoga Partnering for Family Success Program
- MA Chronic Homeless
- Chicago Child-Parent Center
- MA Juvenile Justice
- NYS Recidivism
- UT High Quality Preschool Program
- NYC Incarcerated Youth

### Transaction structuring
- Baltimore, MD

### GHHI feasibility sites
- New York, NY
- Buffalo, NY
- Chicago, IL
- Grand Rapids, MI
- Houston, TX
- Memphis, TN
- Philadelphia, PA
- Providence, RI
- Salt Lake City, UT
- Springfield, MA

GHHI currently has a portfolio of 11 pending transactions – 10 feasibility studies and 1 transaction structuring effort.

Source(s): GHHI analysis of publicly available information.
Transactions can be structured so only demonstrated reductions in cost trigger payments and they have no negative impact on budgets.

**Budgetary effect of PFS project**

USD millions

<table>
<thead>
<tr>
<th>This year’s budget</th>
<th>Total cost-savings</th>
<th>Next year’s budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>10</td>
<td>90</td>
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**Cost abatement**

**New budget**

**Investor repayment**

**Unaffected budget**

**Pay for Success** projects have no impact on the initial budget of the end-payer, but can lower subsequent budget cycles.

**Investors** provide additional capital to start the program and are repaid in subsequent years (USD 5 million shown).

**The end payer** benefits USD 5 million in savings shown. They only pay for success (USD 5 million in capital returns shown):
- A portion of the value created; and
- If and only if the intervention proves successful.

**Payments** are negotiated by the project team and are typically cost-savings based, but may also include new revenue generation, improved margins, or payments for other valuable social goods.

**Pay for Success** provides investment dollars and accountability that the investors will only be repaid if the interventions are proven successful.

**Investors** provide capital in the first years, driving value in subsequent years.

**The payer** returns a percentage of value created to the investor but only when results are delivered.

**Repayment** is conditional on subsequent value creation.

The exact structure is negotiated on a case by case basis to suit needs.

The benefits of the project may continue well after the project has ended.

**Annual cash-flows**

$ millions

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<td>40</td>
<td>20</td>
<td>50</td>
<td>30</td>
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**Payer retained value**

**Investor repayment**

Investment by outside party has no budget impact for payer.

Note(s): Early cost-savings can be used to offset future capital requirements, further limiting risk.

Source(s): GHHI analysis of publicly available information. © www.ghhi.org
Pay for Success projects generate long-term savings by improving health, proving more effective service models, and shaping future health policy.

Value sharing concept

$A$

Investor returns

Cost of care

Health entity retained value

Long term State and CMS Savings

Time

D

E

Pay for Success Project

Transition period

Broader policy roll-out and continuous improvement

Timeline and technical analysis of a success story
1. Investors fund the project.
2. The starting cost of care for patients (A) is reduced (B) from the start of the project (A) to the end (D).
3. The health care provider retains the cost savings, largely passing it through to the investors for capital returns.
4. The price paid for care (C) can be negotiated for all care providers that allows a capital margin to sustainably fund the services going forward.
5. The new rate (C) phases in for all care providers over time (D to E), allowing the other organizations to start offering services and incentivizing early adopters.
6. The public saves the difference between the original cost of care (A) and the new cost of care (C) from the end of the rate transition (E) onward and benefits from a higher quality of care and fewer needed services due to preventative interventions.

Timeline of a failed project
1. Investors fund the project.
2. The interventions fail to lower the cost of care by preventing medical needs.
3. Investors are not repaid their investment because the cost of care did not change.
4. The public has paid no additional funds to anyone because the cost of care did not change.
5. Patients still receive the existing standard of care.
6. There is now evidence that the interventions do not work in the given circumstances.

Policy outcome
In either circumstance new policies can reflect the new evidence developed during the project.

Key takeaway
The long-run public benefit of a successful initiative will substantially outweigh the short and medium-run investment costs.

Note(s):
Model assumes that the cost of providing care is roughly equivalent to the compensation from government.

Source(s):
GHHI analysis of publicly available information.

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Pay for Success is a mechanism to drive change, it is not the end.

Potential purposes of project
- Develop sustainable funding sources for programs,
- Establish evidence or demonstrations that drive policy changes; or
- Establish, fund, and prove new business models.

Source(s): GHHI analysis of publicly available information.
Pay for Success in Public Health
An analysis and recommendations

May 2016
Pay for Success can have a meaningful impact on public health if key issues are addressed.

**Executive summary**

Key issues in Public Health as a whole
There are a number of barriers to implementing Pay for Success in Public Health.

- **System fragmentation** – The public health system is highly fragmented and includes many interdependent layers.

- **Payment arrangements** – There are number of payment arrangement types and each has issues that impact the use of innovative funding mechanisms like Pay for Success.

- **Transaction structure** – There are no fewer than a dozen potential Pay for Success transaction structures in public-health, each with its own benefits and issues.

Recommendations
To address these issues we developed this getting started guide, which should help. You will need to:

- **Take a local-first approach** and determine what your local conditions are in your state and locality, then how that flows upward through the system.

- **Establish the right compensation mechanisms** for your given situation. Pay for Success can be made workable with any payment arrangement, but requires differing levels of 'creativity' to be viable.

- **Determine the structure that fits your mission.** You already have strategic goals; Pay for Success can help you achieve them by following this roadmap.

Next steps
Over the course of the following pages you should be able to:

1. Identify which entities in the public-health system you are working with;
2. Identify your payment arrangement and understand the impact on Pay for Success;
3. Familiarize yourself with the key issues that are possible;
4. Determine which models are workable for you; and
5. Create a check-list of next steps to clearing the path for Pay for Success.
There are numerous types of entities in public health and each plays a different role in Pay for Success projects.

**Government**
Governments entities such as CMS, state offices, and others.

**Health plans**
Health Plans such as Managed Care Organizations (MCOs) that enroll parties and provide insurance.

**Hospitals and clinics**
Hospitals, provider clinics, and other medical facilities that provide the traditional continuum of medical care for patients. They are heavily capital intensive and have complex cost accounting as a result. Determining the right payment is a key issue.

**Intervention providers**
Organizations, typically nonprofits, that provide social services in addition to or in lieu of existing social services such as those services covered by Medicaid State Plans.

**Value based purchasing entities**
An entity that has been set up to contract for the provision of services beyond the traditional continuum of medical care that have medical value, reducing the aggregate system burden.

**Accountable care entities**
Accountable Care Entities (ACEs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. They can function as plans, hospitals, purchasing entities, or integrated systems. We do not analyze them separately. For example, an ACE may be owned by a system, requiring analysis of the system, not the entity.

**Integrated health systems**
Integrated health systems are widely differing aggregations of multiple components. They must be considered individually. Key considerations are where capital enters and leaves the system that can be leveraged for a transaction, which financial relationships are internal transfers, and what the economic basis for payment would be.

Pay for Success transactions, as described earlier, allow outside investors to fund services with a payer returning capital to investors.

Source(s): GHHI analysis of publicly available information.
Fee-for-service arrangements can enable Pay for Success through creative solutions that can be sanctioned by states and approved federally.

Fee-for-service arrangements
Health care providers are paid a set fee for each service such as office visits, tests, or procedures.

States set mandatory and optional Medicaid services in their Medicaid State plan. The Centers for Medicare and Medicaid Services (CMS) reviews all state plan amendments to make sure reimbursement methodologies are consistent with federal statutes and regulations.

States may develop their payment rates based on:
- The costs of providing the service;
- A review of what commercial payers pay in the private market; or
- A percentage of what Medicare pays for equivalent services.

The problem with fee for service
This model removes incentives for investments in preventative care because compensation is based on volume of services provided. Further, many nonmedical services have medical impacts but organizations are not pay fees for those services.

Solving the volume dilemma
1. Allow carving-out capitated sub-populations;
2. Create an outcome-based payment mechanism; or
3. Establish external economic incentives.

Bundled payments can be used for Pay for Success if the bundle includes all services in a sufficiently long time horizon.

Bundled payments
There are a large number of methods of bundling payments. They all rely on grouping services and paying for the group, often to varying degrees of dependence on what services are actually provided.

For example, an organization would be paid once for the average cost of all services associated with a heart-attack. If they can provide fewer or less costly services, they can retain the difference assuming they have the same or better medical outcomes as others not receiving the bundle – such as comparable or lower mortality rates.

The problem with bundles
Bundled payments often cover a relatively short term. The term covered by the bundle limits the investment horizon for preventative services, which limits the potential investment.

The right bundle over the right time
The solution is to create bundles that cover long-enough time-horizons to warrant investments in preventative care.

Managed care arrangements can be used for Pay for Success if the mechanics of rate-setting are amended to provide long-term incentives.

Managed care (capitated) agreements
A health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of health benefits and additional services through contracted arrangements between state agencies and managed care organizations (MCOs). Those organizations agree to a set per member per month (PMPM) payment for their services.

The PMPM payments are periodically readjusted based on the number of persons at different levels of medical risk of a population and the price paid per person in each of those categories.

The problem with short-term managed care
The way rates are set is still based on a fee-for-service calculation of what the expected medical costs will be for a population and the frequency with which they are calculated, often yearly, disincentivizes investments beyond that horizon.

Getting past the rate-setting impasse
The mechanics can be adjusted by establishing long-term agreements including outcome-based payments in lieu of existing State Plan services in managed care contracts for innovative care delivery models as proof of concept.
The structure of transactions can determine which key issues need to be resolved for an effective Pay for Success project.

**Business motives**
There are a number of possible conflicting economic incentives. While they do represent challenges, they can be addressed by, for example, creating frameworks for equitable value distribution.¹

**Double capitalization**
Investors supply the initial capital for Pay for Success transactions; however, when governments agree to be the payer they are self-required to designate the funds for eventual repayment in restricted accounts. While these funds will never change hands if the project fails, it does mean that the project funding is produced twice and unavailable for other spending. This double capitalization is economically inefficient and provides incentives for governments to encourage their private partners to undertake Pay for Success transactions directly.

**Economic pressure**
One mission of the institutions of public health is to improve the value of care provided through delivering additional utility, lowering the cost per unit of utility, or both simultaneously. Economic pressure is ultimately necessary in the evolution of a well functioning market or public health system; however, as a powerful motive careful attention should be paid as it may have adverse or unintended consequences.

**Value creation and basis for payments**
Pay for Success requires determining the appropriate basis for payment due to created value, specifically the marginal free cash flow. It varies widely depending on the public-health entities involved in the construction of a Pay for Success transaction. The most prevalent types are from revenue generation or cost abatement.

Within our analysis the most common forms of value creation were from:
- **Additional revenue** from new or extended plan enrollments, quality improvement incentives, and new services offerings.
- **Reducing net charges** resulting in cash payments made from governments or health plans to their partners in fee for service arrangements,
- **Payments per member per month** changes over time attributable to the intervention in capitated environments, and
- **Variable cost abatement** for hospitals and clinics.

**Payment stabilization**
Governments can actively encourage the private sector to innovate in public-health service delivery, primarily by creating mechanisms or other agreements that stabilize payments. This is a highly complex issue, please see “Opening the Door to Public Health” – a GHHI publication for more.

**Network integrity**
Based on the percentage of medical savings within a system, the economic basis for a transaction can differ widely.

**Including value-creating relationships**
It is possible to create a Pay for Success transaction that does not include the value-creating relationship or an immediate proxy for it such as a Value Based Purchasing entity. These agreements are, however, economically nonspecific, which can create perverse incentives that derail a project.

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¹ For further reading see “Opening the Door to Public Health” a GHHI publication at www.ghhi.org.
Among the models we analyzed, none were perfect, five were workable, and two had the most potential.

### Summary table of models

<table>
<thead>
<tr>
<th>Rating</th>
<th>Payer</th>
<th>Pays for services</th>
<th>Source of value created</th>
<th>Value created</th>
<th>Business conflict</th>
<th>Potential impact scale</th>
<th>Payment issues</th>
<th>Cost basis</th>
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<td>Plans</td>
<td>Plans</td>
<td>Converts acute care $ to prevention</td>
<td>Reducing payments to self</td>
<td>Process and political limits per unit</td>
<td>Double capitalization</td>
<td>Payment reduction</td>
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<td>Reduce plan overhead</td>
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<td>Process and political limits per unit</td>
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<td>Process and political limits per unit</td>
<td>Double capitalization</td>
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<td>Intervention providers</td>
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<td>All systems</td>
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<td>Operating cost reduction</td>
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</table>

### Key findings

1. **Business motive conflicts prevent using most existing health-system relationships for Pay for Success because they threaten existing business models.**
2. **Process and political limits prevent government led projects from reaching potential, but could be addressed by creating a purchasing entity with an appropriate mandate.**
3. **Payment mechanism issues occur in every model and can be addressed in each case, so long as business motives can be addressed.**
4. **The basis for cost-savings calculations is a key variable in determining the financial feasibility for a Pay for Success project.**

Note(s):

* For explanation of stabilization mechanisms, please see page 15.
* For descriptions of key issues, please see page 16.
* Purchasing entities can be leveraged in any circumstance in substitution for or in concert with intervention providers directly.
Business motives complicate governments creating transactions with plans that result in lower government payments to those very plans.

**Financial flows diagram**

**Key issues**
1. Business motive tensions in the government trying to pay the health plan to reduce payments to the health plan. Alternate agreements are possible, but this business motives tension will reduce efficacy.
2. Risk aversion prevents taking on cost neutral programs.
3. Omits value creating relationships by leveraging a cash flow between parties that need to go outside of the existing relationship to secure a partner.
4. Exerts economic pressure on hospitals through health plans.

**Next steps**
1. Explore alternative models; or
2. Identify opportunities to resolve conflicts in business motives.

**Summary**
- Payer: Government
- Uses revenue from: Health plan savings
- Sends revenue to: Health plan
- Value created: Unclear

**Not effective**
- Payment arrangement
- Required consistency
- Leveraged for transaction
- Economic pressure

**Note(s):**
For explanation of stabilization mechanisms, please see page 15.
For descriptions of key issues, please see page 16.

Source(s): GHHI analysis of publicly available information.
Business motives complicate governments creating transactions with hospitals that result in lower government payments to those hospitals.

**Key issues**
1. **Economic pressure** is applied to the whole system through reducing payments to plans and then on to the hospitals, which allow the government to capture value and return capital.
2. **Business motives tensions** exist for the hospitals as they will be trading health plan compensation for government compensation, requiring additional expenditures to incentivize the project.
3. **Hospital marginal cash flow** is based on variable costs only, which reduces the transaction's dollar value and does not pressure systems to better align capacity with need.
4. **Omits value creating relationships.**

**Next steps**
1. Explore alternative models; or
2. Identify opportunities to resolve conflicts in business motives.

**Summary**
- **Payment arrangement**
- **Required consistency**
- **Leveraged for transaction**
- **Economic pressure**

**Not effective**
- **Government**
- **Health plan savings**
- **Hospitals**
- **Value created**

**Note(s):**
For explanation of stabilization mechanisms, please see page 15.
For descriptions of key issues, please see page 16.

Source(s): GHHI analysis of publicly available information.
Governments and systems

Business motives also complicate governments creating transactions with system that result in lower government payments to those systems.

Financial flows diagram

Key issues
1. Economic pressure is applied to the whole system through reducing payments to plans and then on to the hospitals, which allow the government to capture value and return capital.
2. Business motives tensions exist for the hospitals as they will be trading health plan compensation for government compensation, requiring additional expenditures to incentivize the project.
3. Hospital marginal cash flow is based on variable costs only, which reduces the transaction's dollar value and does not pressure systems to better align capacity with need.
4. Omits value creating relationships.

Summary
- Payer: Government
- Uses revenue from: System payments
- Sends revenue to: System
- Value created: Unclear

Not effective
- Payment arrangement
- Required consistency
- Leveraged for transaction
- Economic pressure

Next steps
1. Explore alternative models; or
2. Identify opportunities to resolve conflicts in business motives.

For explanation of stabilization mechanisms, please see page 15.
For descriptions of key issues, please see page 16.

Source(s): GHHI analysis of publicly available information.
Governments can enter into direct transactions with intervention providers to offset health plan spending, though this approach is limited in scalability.

**Financial flows diagram**

- **Government**
- **Intervention provider**
- **Health plan**
- **Hospitals and clinics**

**Revenue diverted**

**Key issues**
1. **Scalability is limited** as government funded efforts require public approvals, whether legislative or regulatory.
2. **Double capitalization** occurs because investors fund the project and the government must have a restricted capital account to cover future expenditures accrued in the period.

**Policy recommendations**
1. **Create a public framework for rapid project development** through an appropriate agency such as an Office of Management and Budget or the appropriate equivalent in the jurisdiction.
2. **Create a Pay for Success fund** that can be used to pay for projects across government where cost-savings as realized recapitalize the fund on a rolling basis. This will not solve the problem but will remove the disincentive at the agency level. *For reference please see the Social Impact Partnership Act S.1089 / H.R. 5170.*

**Next steps: Ready for project development**
1. Identify the intervention and its providers;
2. Identify technical assistance provider* for project development; and

**Summary**
- **Effective but limited scale**
  - **Payer** Governments
  - **Uses revenue from** Health plan savings
  - **Sends revenue to** Intervention provider
  - **Value created** Better medical outcomes

**Note(s):**
* Disclaimer: GHHI is a technical assistance provider for Pay for Success project development.  
  For explanation of stabilization mechanisms, please see page 15.
  For descriptions of key issues, please see page 16.

Source(s): GHHI analysis of publicly available information.
Governments can scale their influence by establishing a single relationship with a purchasing entity that can run many projects under one legislation.

Financial flows diagram

Key issues
1. **Double capitalization occurs.**
2. **Scalability has initial limits** due to public approvals, though a single arrangement with a value based purchasing entity can enable multiple relationships with intervention providers and multiple Pay for Success transactions under the same umbrella.
3. **Additional cost layer** for the purchasing entity, which may or may not be value adding.

Recommendations
1. **Establish a Pay for Success repayment fund.**
2. **Enter into an** agreement with or create an entity that the government that will, in turn, seek to run multiple projects.
3. **Ensure sufficient scope** of work for the entity for the purchasing entity so that the net benefit outweighs the additional cost layer.

Next steps: Ready for development of purchasing entity or relationship with one
1. Identify legal requirements for entering into an agreement;
2. Conduct feasibility study for purchasing entity;
3. Enter into relationship with existing entity or construct one to fill role; and
4. Give them the mandate of improving care through experimentation.

Leveraging purchasing entities with direct relationships with intervention providers in any model will expand transferability between systems and increase scalability.

Summary  High potential but limited precedent
- Payer: Government
- Uses revenue from: Health plan savings
- Sends revenue to: Purchasing entity
- Value created: Better medical outcomes

Note(s): For explanation of stabilization mechanisms, please see page 15. For descriptions of key issues, please see page 16.
Business motives also complicate health plans creating transactions with hospitals that result in lower plan payments to those hospitals.

Financial flows diagram

Key issues
1. **Payment stabilization** – Requires a separate agreement, mechanism, or waiver to enable payment stabilization between the government and health plan.
2. **Business motives tension** – There is a business motives tension in the health plan paying the hospital and clinics to reduce the payment from plan to hospital or clinic.
3. **Omits value creating relationships** by leveraging a cash flow between parties that need to go outside of the existing relationship to secure a partner.
4. **Alignment of costs** for eventual payment between health plan and hospitals because the transaction would leverage the plan payment to the hospital for net charges that includes contribution margin, fixed, and variable costs. The hospital will only generate the variable cost as cashable savings.

Next steps
1. Explore alternative models; or
2. Identify opportunities to resolve conflicts in business motives.

Summary
- **Payer**
- **Uses revenue from**
- **Sends revenue to**
- **Value created**

Not effective
- **Health plan**
- **Hospital savings**
- **Hospitals**
- **Unclear**

Payment arrangement
Required consistency
Leveraged for transaction
Economic pressure

Note(s):
For explanation of stabilization mechanisms, please see page 15.
For descriptions of key issues, please see page 16.

Source(s):
GHHI analysis of publicly available information.
Health plans can be enabled to initiate transactions with intervention providers through government stabilization of payments to plans.

Financial flows diagram

Key issues
1. **Payment stabilization is required** from government to plan through an agreement, mechanism, or waiver to enable returning capital to investors.
2. **Low transference between systems** due to the bilateral nature of the transactions, it is hard to scale intervention services to new health plans.

Recommendations
- Establish payment stability mechanism.
- Establish a known mechanism to expand service offerings to other health plans and to other intervention providers.

Next steps: Ready for project development
1. Identify the intervention and its providers; and
2. Identify technical assistance provider* for project development; then

Summary
- High potential no precedent
- Payer: Health plan
- Uses revenue from: Hospital savings
- Sends revenue to: Intervention provider
- Value created: Better medical outcomes

Note(s):
For explanation of stabilization mechanisms, please see page 15.
For descriptions of key issues, please see page 16.

Source(s): GHHI analysis of publicly available information.
Hospitals entering into transactions with intervention providers require multiple financial assurances and are limited by their own capital intensity.

Financial flows diagram

Key issues
1. Payment stabilization is required from government to plan.
2. Payment stabilization is required from plan to hospitals or clinics through an agreement or other mechanism to ensure the project can return capital to investors.
3. Hospital marginal cash flow is based on variable costs only, which reduces the transaction’s dollar value and does not pressure systems to better align capacity with need.

Recommendations
• Stabilize payments between government and plans.
• Stabilize payments between plans and hospitals.

Next steps: Ready for project development
1. Identify the intervention and its providers; and
2. Identify technical assistance provider* for project development; then

Summary
Limited potential no precedent
- Payer: Hospitals
- Uses revenue from: Variable cost savings
- Sends revenue to: Intervention provider
- Value created: Better medical outcomes

Note(s): For explanation of stabilization mechanisms, please see page 15.
For descriptions of key issues, please see page 16.
Systems can enter into transactions with basic financial assurances but are limited by their own capital intensity and internal business motives.

**Financial flows diagram**

**Government**

**Integrated system**

**Health plan**

**Hospitals and clinics**

**Intervention provider or purchasing entities**

**PFS**

**Needed payment stabilization**

**Key issues**
1. Payment stabilization is required from government to plan.
2. Internal system transfers are not a source of marginal cash-flow that can be leveraged.
3. System marginal cash flow is based on the variable costs of care only.
4. Low transference between systems.

**Recommendations**
1. Stabilize payments between the government and the system.

**Summary**
- Limited potential no precedent
  - System
  - Variable cost savings
  - Intervention provider
  - Better medical outcomes

**Next steps: Ready for project development**
1. Identify the intervention and its providers; and
2. Identify technical assistance provider* for project development; then

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Note(s):
- For explanation of stabilization mechanisms, please see page 15.
- For descriptions of key issues, please see page 16.

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Source(s): GHHI analysis of publicly available information.